SECTION 7

Ambulatory care

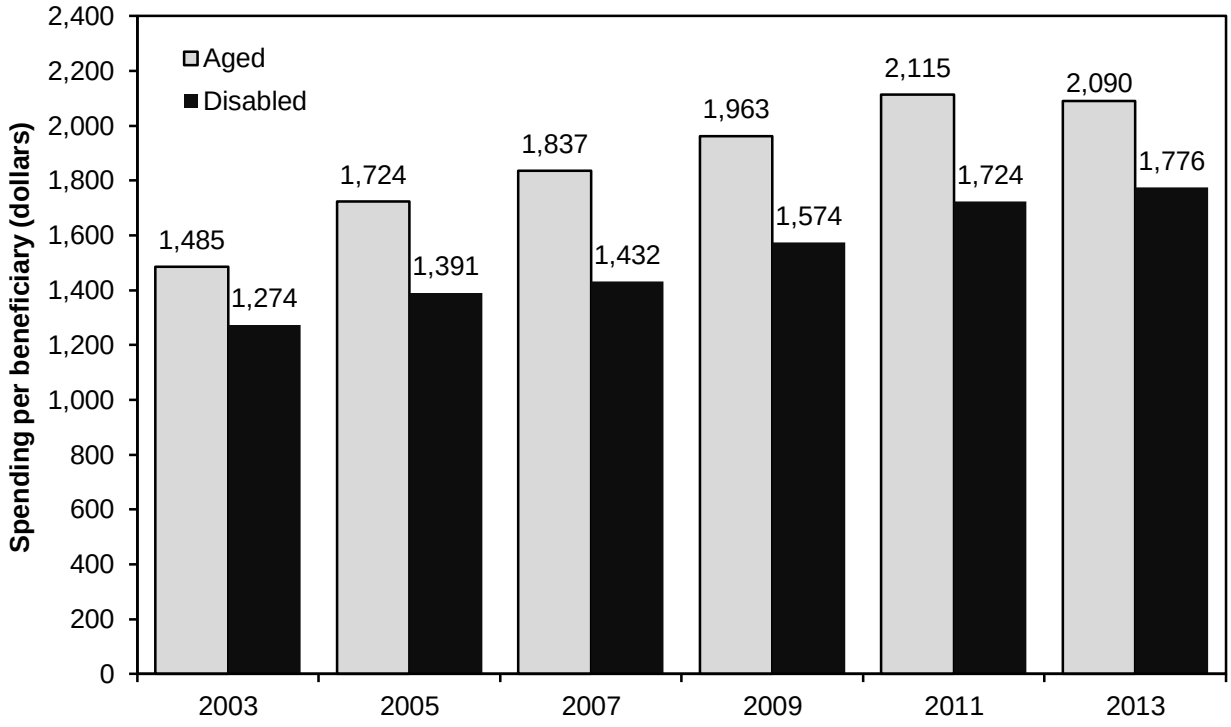
Physicians and other health professionals

Hospital outpatient services

Ambulatory surgical centers

Imaging services

Chart 7-1. Medicare spending per FFS beneficiary on services in the fee schedule for physicians and other health professionals, 2003–2013

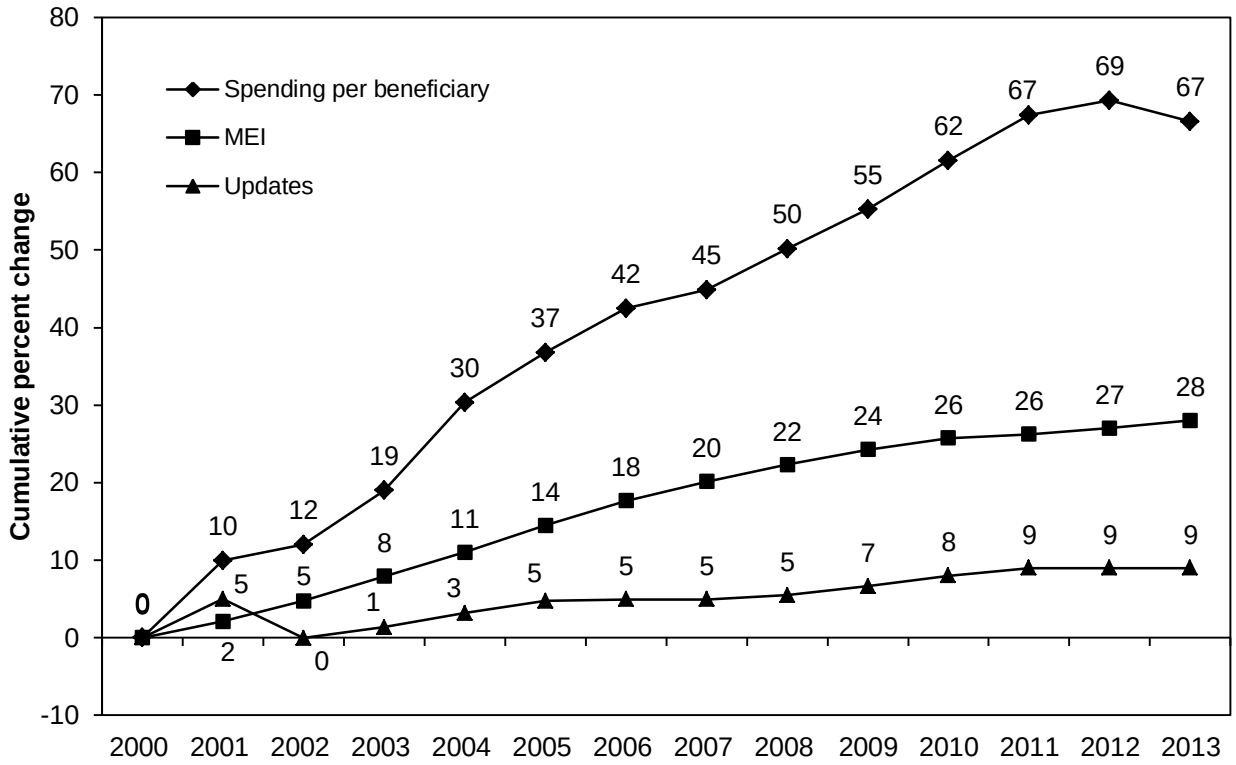


Note: FFS (fee-for-service). Dollar amounts are Medicare spending only and do not include beneficiary coinsurance. The category "disabled" excludes beneficiaries who qualify for Medicare because they have end-stage renal disease. All beneficiaries ages 65 and over are included in the "aged" category.

Source: **AT THE TIME THIS DATA BOOK WAS PREPARED, THE MEDICARE TRUSTEES' REPORT (WHICH IS THE CUSTOMARY SOURCE OF DATA FOR THIS CHART) HAD NOT YET BEEN RELEASED FOR 2015. THIS CHART REFLECTS DATA FROM THE 2014 MEDICARE TRUSTEES' REPORT. THE READER IS ADVISED TO CONSULT THE 2015 TRUSTEES' REPORT DIRECTLY, WHEN AVAILABLE, FOR THE MOST CURRENT VERSION OF THESE DATA.**

- The fee schedule for physicians and other health professionals includes a broad range of services such as office visits, surgical procedures, and a variety of diagnostic and therapeutic services furnished in all health care settings. "Other health professionals" refers to nurse practitioners, physician assistants, chiropractors, and physical therapists.
- Except for a small decrease in spending for aged beneficiaries in 2013, FFS spending per beneficiary for fee-schedule services has increased annually. From 2003 to 2013, spending grew 40 percent.
- Growth in spending on fee-schedule services is one of several contributing factors in Part B premium increases over this period.
- Per capita spending for disabled beneficiaries (under age 65) is lower than per capita spending for aged beneficiaries. In 2013, for example, per capita spending for disabled beneficiaries was $1,776 compared with $2,090 for aged beneficiaries.

Chart 7-2. Volume growth has raised physician spending more than input prices and payment updates, 2000–2013



Note: MEI (Medicare Economic Index).

Source: **AT THE TIME THIS DATA BOOK WAS PREPARED, THE MEDICARE TRUSTEES' REPORT (WHICH IS THE CUSTOMARY SOURCE OF DATA FOR THIS CHART) HAD NOT YET BEEN RELEASED FOR 2015. THIS CHART REFLECTS DATA FROM THE 2014 MEDICARE TRUSTEES' REPORT. THE READER IS ADVISED TO CONSULT THE 2015 TRUSTEES' REPORT DIRECTLY, WHEN AVAILABLE, FOR THE MOST CURRENT VERSION OF THESE DATA.**

- From 2000 to 2013, Medicare spending per beneficiary for physician services increased by 67 percent.
- Spending per beneficiary grew much more rapidly over the period than both the payment rate updates and the MEI. Physician fee-schedule payment updates totaled 9 percent, and the MEI increased 28 percent.
- Growth in the volume of services contributed much more to the rapid increase in Medicare spending than payment rate updates. Both factors—updates and volume growth—combined to increase physician revenues.

Chart 7-3. Medicare beneficiaries reported better ability to get timely appointments with physicians compared with privately insured individuals, 2011–2014

	Medicare (ages 65 or older)				Private insurance (ages 50–64)			
Survey question	2011	2012	2013	2014	2011	2012	2013	2014
Unwanted delay in getting an appointment: Among those who needed an appointment, "How often did you have to wait longer than you wanted to get a doctor's appointment?"								
For routine care								
Never	74%	77%[b]	73%	72%[a]	71%	72%	69%	69%[a]
Sometimes	18	17[b]	20	20[a]	21	21[b]	23	23[a]
Usually	3	3	3	3	4	3	4	4
Always	2[b]	2[b]	3	3	3	3	3	3
For illness or injury								
Never	82	84	82	83[a]	79	80	77	79[a]
Sometimes	14	12	14	12[a]	17	16	17	16[a]
Usually	2	2	2	2	2	2	3[a]	2
Always	1	1	1	1[a]	1[b]	2[a]	2	2[a]

Note: Numbers may not sum to 100 percent due to rounding. Missing responses ("Don't Know" or "Refused") are not presented. Overall sample sizes for each group (Medicare and privately insured) were 4,000 in years 2011 to 2014. Sample sizes for individual questions varied.
[a] Statistically significant difference (at a 95 percent confidence level) between the Medicare and privately insured samples in the given year.
[b] Statistically significant difference (at a 95 percent confidence level) from 2013 within the same insurance coverage category.

Source: MedPAC-sponsored annual telephone surveys conducted 2011–2014.

- Most Medicare beneficiaries have one or more doctor appointments in a given year. Their ability to schedule timely appointments is one indicator of access that we examine.
- Medicare beneficiaries report better access to physicians for appointments than privately insured individuals ages 50 to 64. For example, in 2014, 72 percent of Medicare beneficiaries and 69 percent of privately insured individuals reported "never" having to wait longer than they wanted to get an appointment for routine care.
- Medicare beneficiaries also report more timely appointments for injury and illness than their privately insured counterparts.
- Appointment scheduling for illness and injury is better than for routine care appointments for both Medicare beneficiaries and privately insured individuals.

Chart 7-4. Medicare and privately insured patients who were looking for a new physician reported more difficulty finding one in primary care, 2011–2014

	Medicare (ages 65 or older)				Private insurance (ages 50–64)			
Survey question	2011	2012	2013	2014	2011	2012	2013	2014
Looking for a new physician: "In the past 12 months, have you tried to get a new …?" (Percent answering "Yes")								
Primary care physician	6%[b]	7%[b]	7%	8%	7%	7%	8%	8%
Specialist	14[b]	13[b]	14[b]	17	16	18	16	17
Getting a new physician: Among those who tried to get an appointment with a new physician, "How much of a problem was it finding a primary care doctor/specialist who would treat you? Was it …"								
Primary care physician								
No problem	65	72	70	67	68	75	67	63
Small problem	12	14	11	16	16	9	15	16
Big problem	23[b]	14	17	15	14[a]	15	18	19
Specialist								
No problem	84	87	86	85	86	86	87	85
Small problem	8	6	8	7	8	7[b]	6	9
Big problem	7	7	5	7	6	7	7	6

Note: Numbers may not sum to 100 percent due to rounding. Missing responses ("Don't Know" or "Refused") are not presented. Overall sample sizes for each group (Medicare and privately insured) were 4,000 in 2011 to 2014. Sample sizes for individual questions varied.
[a] Statistically significant difference (at a 95 percent confidence level) between the Medicare and privately insured samples in the given year.
[b] Statistically significant difference (at a 95 percent confidence level) from 2014 within the same insurance coverage category.

Source: MedPAC-sponsored annual telephone surveys, conducted 2011–2014.

- In 2014, only 8 percent of Medicare beneficiaries and privately insured individuals reported looking for a new primary care physician. This finding suggests that most people were either satisfied with their current physician or did not need to look for one.
- Of the 8 percent of Medicare beneficiaries who looked for a new primary care physician in 2014, 31 percent reported problems finding one: 15 percent reported their problem as "big," and 16 percent reported their problem as "small." Although this number indicates that only about 2 percent of the total Medicare population reported problems finding a primary care physician, the Commission is concerned about the continuing trend of greater problems accessing primary care.
- Of the 8 percent of privately insured individuals who looked for a new primary care physician in 2014, 35 percent reported problems finding one: 19 percent reported their problem as "big," and 16 percent reported their problem as "small."
- In 2014, Medicare beneficiaries and privately insured individuals were more likely to report problems accessing a new primary care physician than a new specialist.

Chart 7-5. Access to physician care was better for Medicare beneficiaries than privately insured individuals, but minorities in both groups reported unwanted delays slightly more frequently, 2014

	Medicare (ages 65 or older)			Private insurance (ages 50–64)		
Survey question	All	White	Minority	All	White	Minority
Unwanted delay in getting an appointment: Among those who needed an appointment, "How often did you have to wait longer than you wanted to get a doctor's appointment?"						
For routine care						
Never	72%[a]	73%[a]	72%[a]	69%[a]	70%[a]	66%[a]
Sometimes	20[a]	20[a]	19[a]	23[a]	23[a]	24[a]
Usually	3	3	3	4	4	4
Always	3	2	3	3	2[b]	5[b]
For illness or injury						
Never	83[a]	84[ab]	80[a]	79[a]	80[ab]	73[ab]
Sometimes	12[a]	12[a]	14[a]	16[a]	16[ab]	19[ab]
Usually	2	2	2	2	2	3
Always	1[a]	1	2[a]	2[a]	2[b]	4[ab]

Note: Numbers may not sum to 100 percent due to rounding. Missing responses ("Don't Know" or "Refused") are not presented. Overall sample size for each group (Medicare and privately insured) was 4,000 in 2014. Sample size for individual questions varied.
[a] Statistically significant difference (at a 95 percent confidence level) between the Medicare and privately insured populations in the given race category.
[b] Statistically significant difference (at a 95 percent confidence level) by race within the same insurance category.

Source: MedPAC-sponsored telephone surveys conducted in 2014.

- In 2014, Medicare beneficiaries reported better access to physicians for appointments than privately insured individuals ages 50 to 64.
- Access varied by race, with minorities more likely than Whites to report access problems in both insurance categories. For example, in 2014, 84 percent of White Medicare beneficiaries reported "never" having to wait longer than they wanted to get an appointment for an illness or injury compared with 80 percent of minority beneficiaries.
- Although minorities experienced slightly more access problems, minorities with Medicare were less likely to experience problems than minorities with private insurance.

Chart 7-6. Differences in obtaining access to a new physician did not vary significantly between White and minority Medicare patients, 2014

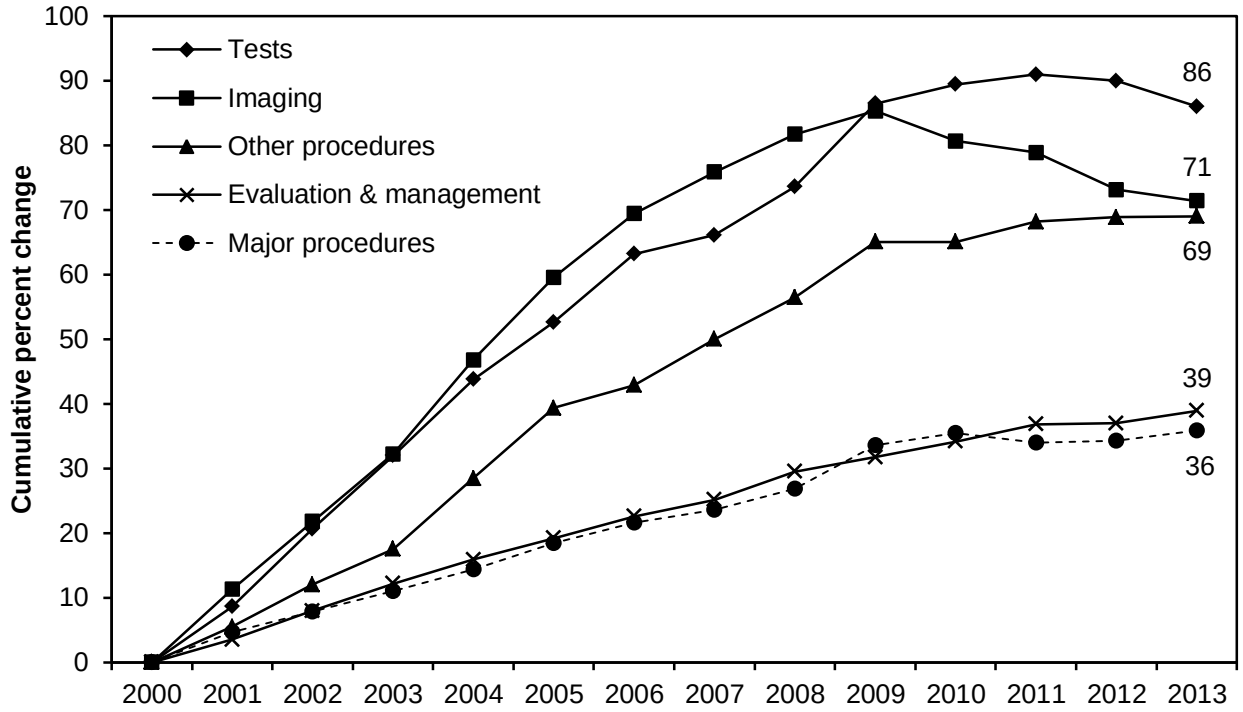
	Medicare (ages 65 or older)			Private insurance (ages 50–64)		
Survey question	All	White	Minority	All	White	Minority
Looking for a new physician: "In the past 12 months, have you tried to get a new …?"						
Primary care physician	8%	8%	8%	8%	7%	9%
Specialist	17	18[b]	14[b]	17	18[b]	14[b]
Getting a new physician: Among those who tried to get an appointment with a new physician, "How much of a problem was it finding a primary care doctor/specialist who would treat you? Was it …"						
Primary care physician						
No problem	67	67	69	63	60	72
Small problem	16	16	16	16	17	14
Big problem	15	15	13	19	22	13
Specialist						
No problem	85	85	83	85	86	84
Small problem	7	7	5	9	8	10
Big problem	7	7	8	6	6	7

Note: Numbers may not sum to 100 percent due to rounding. Missing responses ("Don't Know" or "Refused") are not presented. Overall sample size for each group (Medicare and privately insured) was 4,000 in 2014. Sample size for individual questions varied.
[a] Statistically significant difference (at a 95 percent confidence level) between the Medicare and privately insured populations in the given race category.
[b] Statistically significant difference (at a 95 percent confidence level) by race within the same insurance category.

Source: MedPAC-sponsored telephone surveys conducted in 2014.

- Among the small percentage of Medicare beneficiaries and privately insured individuals looking for a new specialist, minorities were slightly more likely than Whites to report problems finding one, although differences in 2014 were small and not statistically significant.

Chart 7-7. Growth in volume per beneficiary of physician and other health professional services, 2000–2013

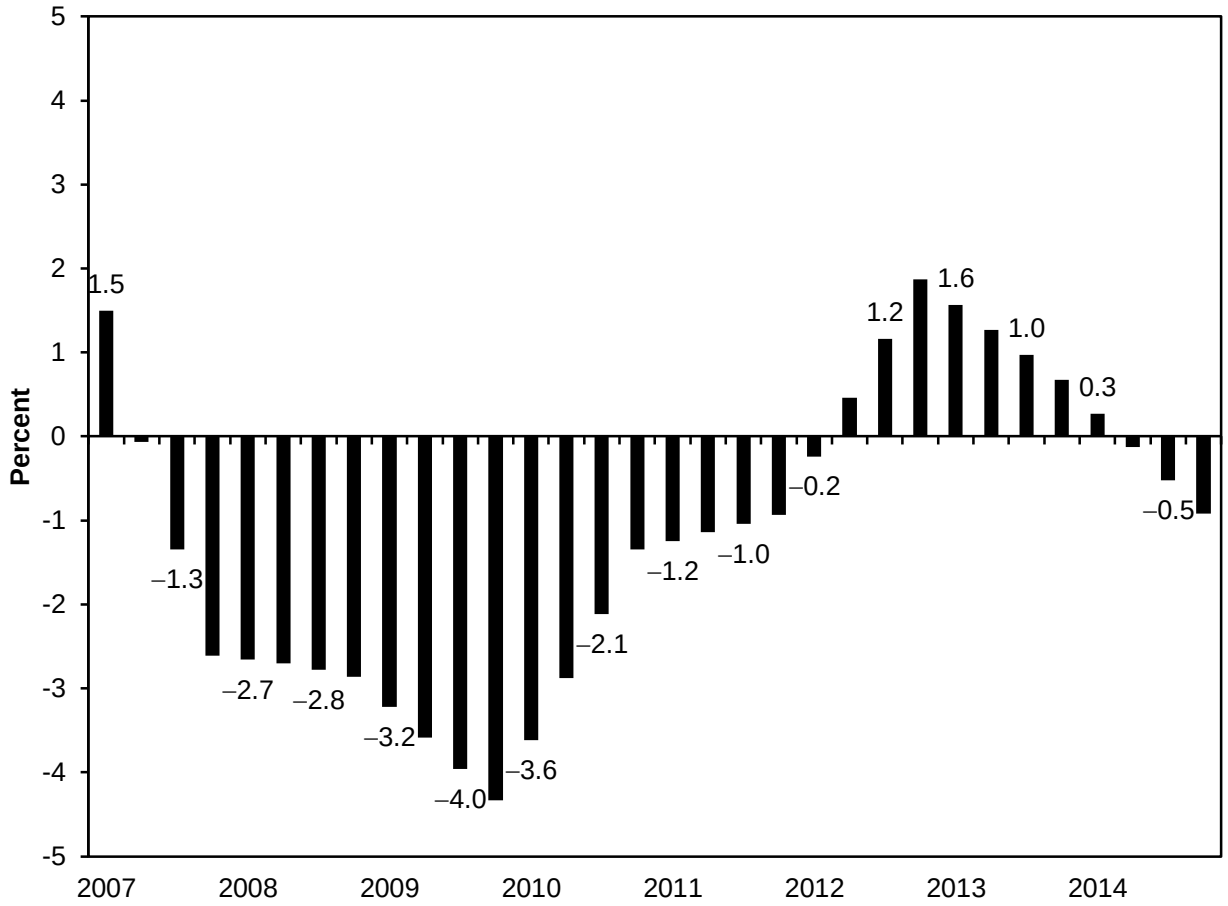


Note: "Volume" refers to the units of service multiplied by relative value units from the fee schedule for services furnished by physicians and other qualified health professionals. Volume for all years is measured on a common scale, with relative value units for 2013. Volume growth for evaluation and management (E&M) from 2009 to 2010 is not directly observable because of a change in payment policy for consultations. To compute cumulative volume growth for E&M through 2013, we used a growth rate for 2009 to 2010 of 1.9 percent, which is the average of the 2008 to 2009 growth rate of 1.7 percent and the 2010 to 2011 growth rate of 2.0 percent.

Source: MedPAC analysis of claims data for 100 percent of Medicare beneficiaries.

- From 2000 to 2013, the volume of some services furnished by physicians and other qualified health professionals grew much more than others.
- The volume of tests grew by 86 percent, the volume of imaging grew by 71 percent, and the volume of "other procedures" (procedures other than major procedures) grew by 69 percent. The comparable growth rates for E&M services and major procedures were only 39 percent and 36 percent, respectively.
- Volume growth increases Medicare spending, limiting funds available for other priorities in the federal budget and requiring taxpayers and beneficiaries to contribute more to the Medicare program. Overall volume increases translate directly to growth in both Part B spending and premiums. Rapid volume growth may be a sign that some services in the physician fee schedule are mispriced.

Chart 7-8. Changes in physicians' professional liability insurance premiums, 2007–2014



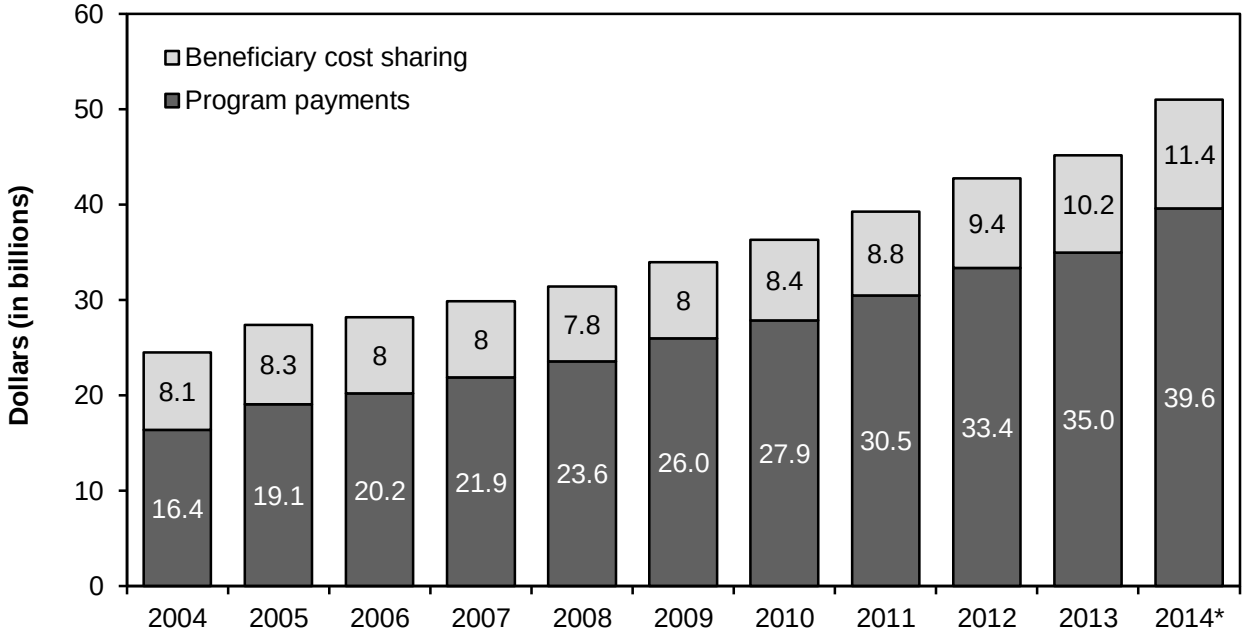
Note: Bars represent a four-quarter moving average percent change.

Source: CMS, Office of the Actuary. Data are from CMS's Professional Liability Physician Premium Survey.

- Professional liability insurance (PLI) accounts for 4.3 percent of total payments under the physician fee schedule. PLI premiums generally follow a cyclical pattern, alternating between periods of low premiums—characterized by high investment returns for insurers and vigorous competition—and high premiums—characterized by declining investment returns and market exit.

- The change in PLI premiums over the last 13 years reflects a cyclical pattern. Premiums increased from 2002 through 2006 (data not shown) and then declined from the second quarter of 2007 through the first quarter of 2012. Premiums grew slowly from the second quarter of 2012 through the first quarter of 2014 and began falling during the second quarter of 2014.

Chart 7-9. Spending on hospital outpatient services covered under the outpatient PPS, 2004–2014



Note: PPS (prospective payment system). Spending amounts are for services covered by the Medicare outpatient PPS. They do not include services paid on separate fee schedules (e.g., ambulance services and durable medical equipment) or those paid on a cost basis (e.g., corneal tissue acquisition and flu vaccines) or payments for clinical laboratory services. *Estimate.

Source: CMS, Office of the Actuary.

- Overall spending by Medicare and beneficiaries on hospital outpatient services covered under the outpatient PPS from calendar year 2004 to 2014 increased by 108 percent, reaching $51 billion. The Office of the Actuary projects continued growth in total spending, averaging 9.4 percent per year from 2014 to 2016.

- In 2001, the first full year of the outpatient PPS, spending under the PPS was $20.1 billion, including $12.1 billion by the program and $8.0 billion in beneficiary cost sharing. Spending under the outpatient PPS is expected to rise to $51 billion in 2014 ($39.6 billion in program spending, $11.4 billion in beneficiary copayments). The outpatient PPS accounted for about 6 percent of total Medicare spending by the program in 2014.

- Beneficiary cost sharing under the outpatient PPS includes the Part B deductible and coinsurance for each service. Under the outpatient PPS, beneficiary cost sharing is generally higher than for other sectors, about 22 percent in 2013. Chart 7-13 provides more detail on coinsurance.

Chart 7-10. Most hospitals provide outpatient services

Year	Hospitals	Percent offering		
		Outpatient services	Outpatient surgery	Emergency services
2004	3,882	94%	86%	N/A
2006	3,651	94	86	N/A
2008	3,607	94	87	N/A
2010	3,518	95	90	N/A
2012	3,483	95	91	93%
2013	3,456	96	92	93
2014	3,429	96	92	93

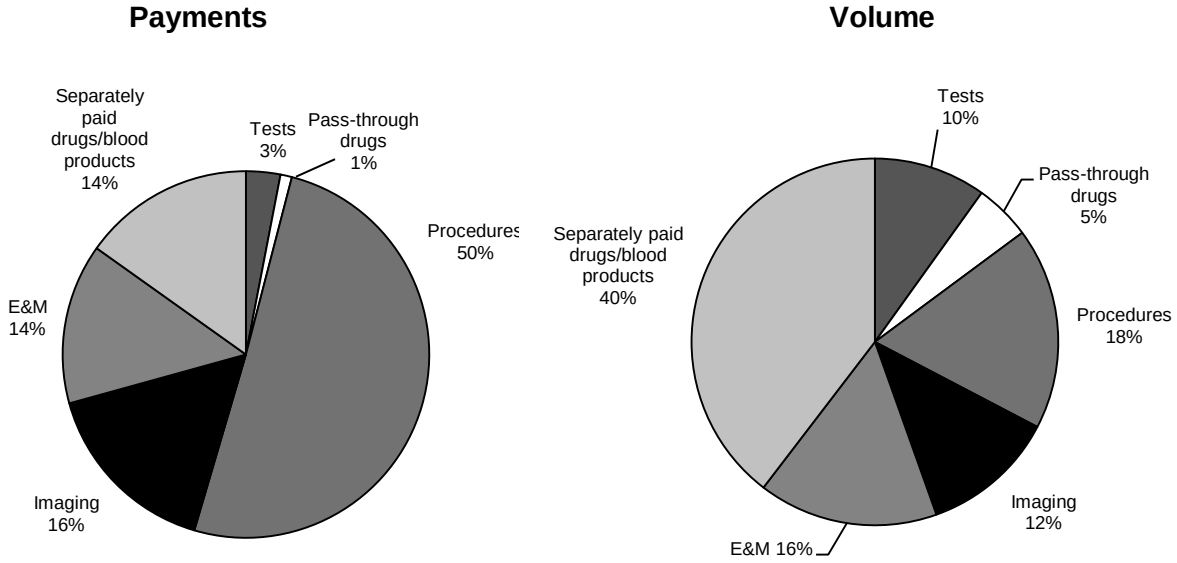
Note: N/A (not applicable). We list emergency services from 2004 through 2010 as "N/A" because the data source we used in this chart changed the variable for identifying hospitals' provision of emergency services. We believe this change in variable definition makes it appear that the percentage of hospitals providing emergency services increased sharply from 2010 to 2012, but we question whether such a large increase actually occurred. This chart includes services provided or arranged by short-term hospitals and excludes long-term, Christian Science, psychiatric, rehabilitation, children's, critical access, and alcohol/drug hospitals.

Source: Medicare Provider of Services files from CMS.

- The number of hospitals that furnish services under Medicare's outpatient prospective payment system (PPS) sharply declined from 2002 through 2006, largely because of growth in the number of hospitals converting to critical access hospital status, which allows payment on a cost basis. Since 2006, the decline in the number of outpatient PPS hospitals has slowed.

- The percent of hospitals providing outpatient services remained stable, and the percent offering outpatient surgery steadily increased from 2004 through 2014. The percent offering emergency services has remained stable over the period we are able to measure accurately (in 2011, CMS changed the variable in the Provider of Services file we use to calculate the share of hospitals offering emergency services, so the numbers for 2012 through 2014 are not precisely comparable with prior years).

Chart 7-11. Payments and volume of services under the Medicare hospital outpatient PPS, by type of service, 2013



Note: PPS (prospective payment system), E&M (evaluation and management). Payments include both program spending and beneficiary cost sharing but do not include hold-harmless payments. Services are grouped into evaluation and management, procedures, imaging, and tests according to the Berenson–Eggers Type of Service classification developed by CMS. Pass-through drugs and separately paid drugs and blood products are classified by their payment status indicator. Percentages may not sum to 100 percent due to rounding.

Source: MedPAC analysis of standard analytic file of outpatient claims for 2013.

- Hospitals provide many types of services in their outpatient departments, including emergency and clinic visits, imaging and other diagnostic services, laboratory tests, and ambulatory surgery.
- The payments for services are distributed differently than volume. For example, in 2013, procedures accounted for 50 percent of payments but only 18 percent of volume.
- Procedures (e.g., endoscopies, surgeries, and skin and musculoskeletal procedures) accounted for the greatest share of payments for services (50 percent) in 2013, followed by imaging services (16 percent), separately paid drugs and blood products (14 percent), and evaluation and management services (14 percent).

Chart 7-12. Hospital outpatient services with the highest Medicare expenditures, 2013

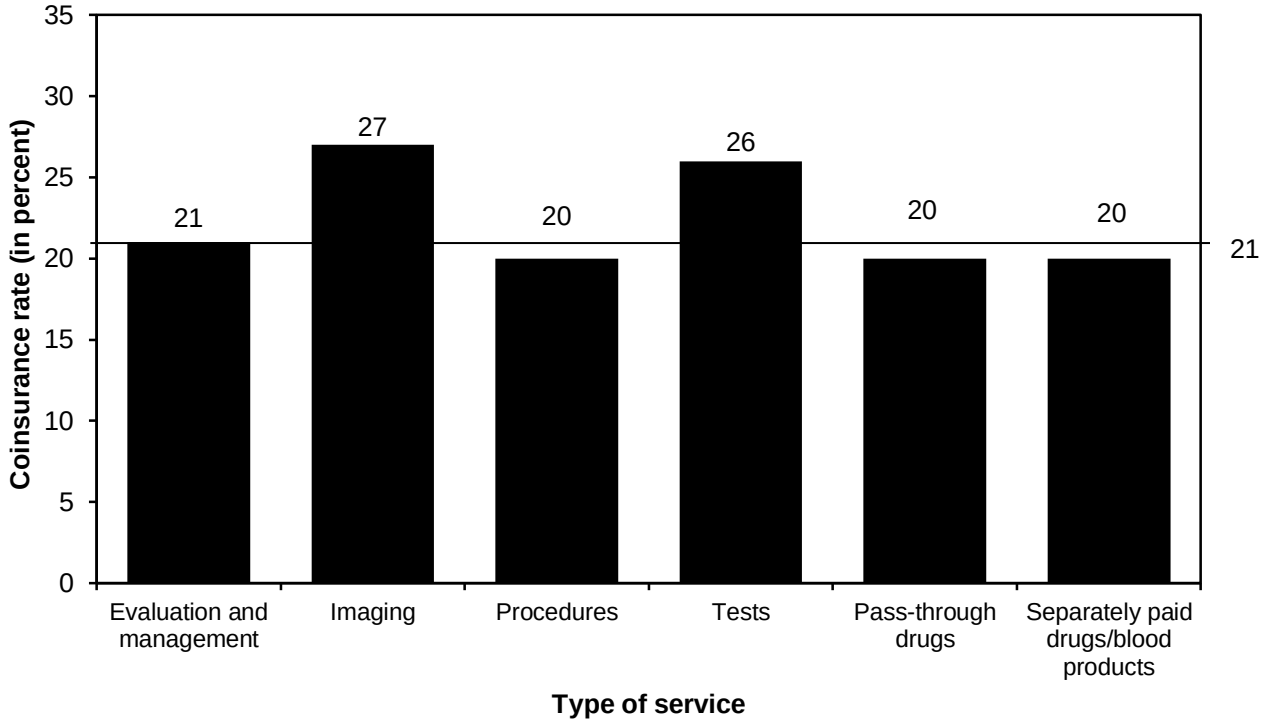
APC title	Share of payments	Volume (thousands)	Payment rate
Total	43%		
All emergency visits	6	12,634	$202
All clinic visits	5	26,329	77
Diagnostic cardiac catheterization	2	476	2,650
Level II extended assessment & management composite	2	2,297	798
Cataract procedures with IOL insert	2	512	1,730
Level II implantation of cardioverter-defibrillators[a]	2	26	30,680
Level I implantation of cardioverter-defibrillators[b]	2	34	22,512
Transcatheter placement of intracoronary drug-eluting stents	2	103	7,763
Level I plain film except teeth	2	15,076	46
Lower gastrointestinal endoscopy	2	1,112	691
Level II endovascular revascularization of the lower extremity	1	84	8,657
Level II echocardiogram without contrast	1	1,677	390
Level III radiation therapy[c]	1	1,298	484
Level II drug administration	1	15,345	39
Level II cardiac imaging	1	847	680
Coronary angioplasty, valvuloplasty, and level I endovascular revascularization of the lower extremity	1	164	4,023
Combined abdomen and pelvis CT with contrast	1	1,110	483
Level II laparoscopy	1	150	3,487
Computed tomography without contrast	1	2,790	174
Level III nerve injections	1	865	566
Level III cystourethroscopy and other genitourinary procedures	1	284	1,909
CT and CTA with contrast composite	1	678	682
Insertion/replacement/conversion of permanent dual chamber pacemaker or pacing electrode	1	45	10,187
MRI and magnetic resonance angiography without contrast material	1	1,185	339
Level I upper gastrointestinal procedures	1	808	623
Average APC		416	143

Note: APC (ambulatory payment classification), IOL (intraocular lens), CT (computed tomography), CTA (computed tomography angiography), MRI (magnetic resonance imaging). The payment rate for "all emergency visits" is a weighted average of payment rates from 10 APCs, and the payment rate for "all clinic visits" is a weighted average of payment rates from 5 APCs.
[a]In 2012, this APC was Insertion/replacement/repair of cardioverter-defibrillator leads.
[b]In 2012, this APC was Insertion of cardioverter-defibrillator pulse generator.
[c]In 2012, this APC was intensity-modulated radiation therapy treatment delivery.

Source: MedPAC analysis of 5 percent analytic files of outpatient claims for calendar year 2013.

- Although the outpatient prospective payment system covers thousands of services, expenditures are concentrated in a handful of categories that have high volume, high payment rates, or both.

Chart 7-13. Medicare coinsurance rates, by type of hospital outpatient service, 2013



Note: Services were grouped into categories of evaluation and management, imaging, procedures, and tests according to the Berenson–Eggers Type of Service classification developed by CMS. Pass-through drugs and separately paid drugs and blood products are classified by their payment status indicators.

Source: MedPAC analysis of the standard analytic files of outpatient claims for 2013.

- Before CMS began using the outpatient prospective payment system (PPS), beneficiary coinsurance payments for hospital outpatient services were based on hospital charges, while Medicare payments were based on hospital costs. As hospital charges grew faster than costs, coinsurance represented an increasingly large share of total payments.
- In adopting the outpatient PPS, the Congress froze the dollar amounts for coinsurance. Consequently, beneficiaries' share of total payments has declined over time.
- The coinsurance rate differs for each service. Some services, such as imaging, have relatively high rates of coinsurance—27 percent in 2013. Other services, such as procedures, have coinsurance rates of 20 percent.
- In 2013, the average coinsurance rate was about 21 percent. There is a small discrepancy between the average coinsurance rate of 21 percent and the average cost sharing of 22 percent listed on Chart 7-9 because the cost sharing includes both coinsurance and the Part B deductible.

Chart 7-14. Effects of hold-harmless and SCH transfer payments on hospitals' outpatient revenue, 2011–2013

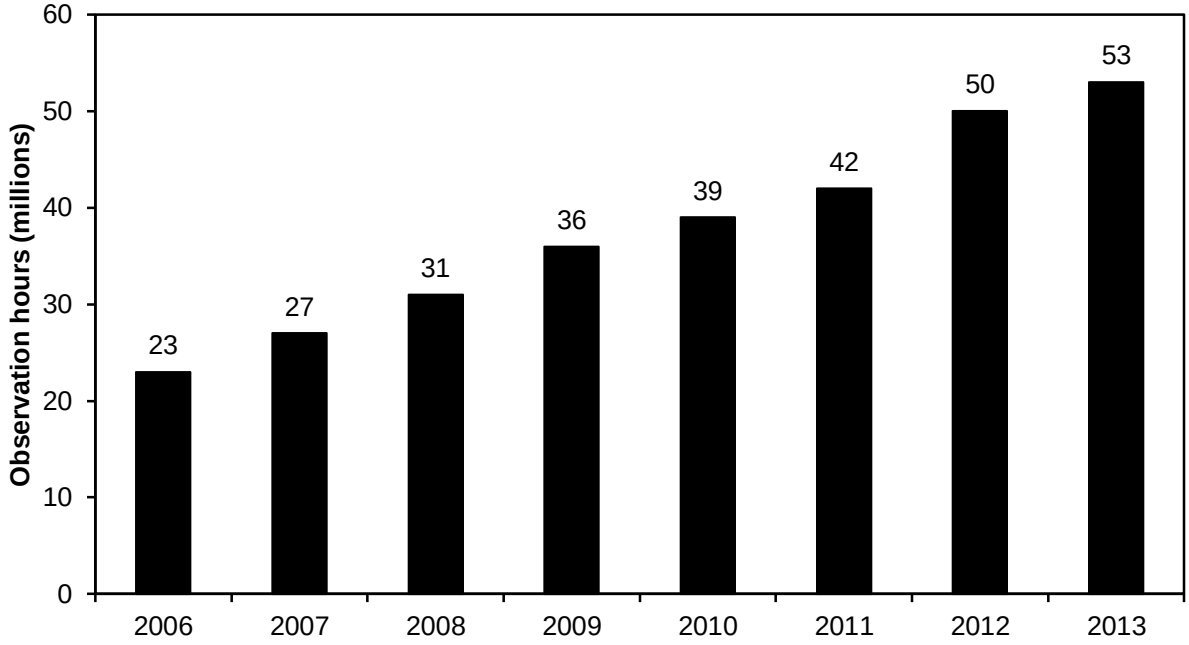
Hospital group	2011 Number of hospitals	2011 Share of payments from hold harmless and SCH transfer	2012 Number of hospitals	2012 Share of payments from hold harmless and SCH transfer	2013 Number of hospitals	2013 Share of payments from hold harmless and SCH transfer
All hospitals	3,087	0.4%	3,029	0.4%	2,877	0.1%
Urban	2,197	–0.3	2,170	–0.3	2,061	–0.4
Rural SCHs	378	8.0	371	8.2	354	6.2
Rural ≤ 100 beds	375	3.1	356	4.2	340	0.7
Other rural	136	–0.1	132	–0.1	121	–0.4
Major teaching	259	–0.3	260	–0.4	251	–0.3
Other teaching	730	–0.1	712	–0.1	684	–0.2
Nonteaching	2,097	1.2	2,057	1.2	1,941	0.5

Note: SCH (sole community hospital). The number of hospitals in groups in 2011 and 2013 do not sum to total because we could not classify one hospital in both years.

Source: MedPAC analysis of Medicare Cost Report files from CMS.

- Medicare implemented the hospital outpatient prospective payment system (PPS) in 2000. Previously, Medicare paid for hospital outpatient services on the basis of hospital costs. Recognizing that some hospitals might receive lower payments under the outpatient PPS than under the earlier system, the Congress established transitional corridor payments. The corridors were designed to make up part of the difference between payments that hospitals would have received under the old payment system and those under the new outpatient PPS.
- Transitional corridor payments expired for most hospitals at the end of 2003. However, some rural hospitals continued to receive a special category of transitional corridor payments called "hold harmless" (HH) through 2012. Qualifying hospitals receive the greater of the payments they would have received from the previous system or the actual outpatient PPS payments.
- Hospitals that qualified for HH payments in 2004 and 2005 included rural SCHs and other small rural hospitals (100 or fewer beds). After 2005, small rural hospitals continued to be eligible for HH payments, but SCHs no longer qualified. In 2006, CMS implemented a policy (the "SCH transfer") that increased outpatient payments to rural SCHs by 7.1 percent above the standard rates. This policy is made budget neutral by reducing payments to all other hospitals. Finally, the Congress reestablished HH payments for SCHs that had 100 or fewer beds in 2009 and extended HH payments to all SCHs in 2010 and 2011. HH payments for SCHs that had more than 100 beds expired on March 1, 2012, and expired for SCHs and rural hospitals that had 100 or fewer beds on January 1, 2013.
- HH payments and the SCH transfer represented 0.4 percent of total outpatient PPS payments for all hospitals in 2011. However, the percentage of total outpatient payments from these policies was 8.0 percent for rural SCHs and 3.1 percent for small rural hospitals. Data from 2012 and 2013 indicate transfer and HH payments to rural SCHs were 8.2 percent of their outpatient revenue in 2012 and 6.2 percent in 2013. Hold-harmless payments were 4.2 percent of total outpatient payments to small rural hospitals in 2012, but only 0.7 percent in 2013.

Chart 7-15. Number of observation hours increased, 2006–2013



Source: MedPAC analysis of Limited Data Set claims for the outpatient prospective payment system 2006–2013.

- Hospitals use observation care to determine whether a patient should be hospitalized for inpatient care, transferred to an alternative treatment setting, or sent home.
- Medicare began providing separate payments to hospitals for some observation services on April 1, 2002. Previously, the observation services were packaged into the payments for the emergency department or clinic visits that occurred with observation care.
- The number of observation hours (both packaged and separately paid) has increased substantially, from about 23 million in 2006 to 53 million in 2013. Before 2006, it was difficult to count the total number of observation hours because hospitals were not required to report packaged observation hours on Medicare claims.

Chart 7-16. Number of Medicare-certified ASCs increased by 15 percent, 2007–2014

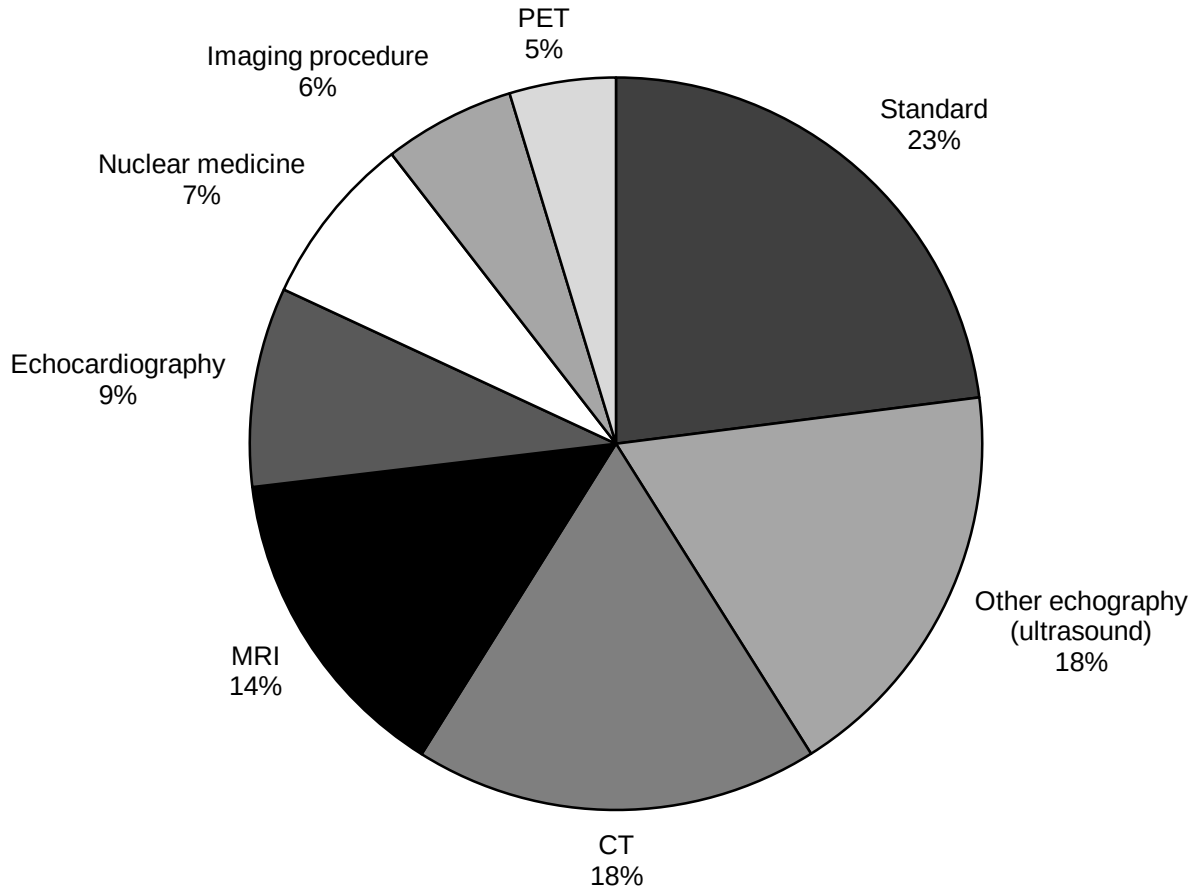
	2007	2008	2009	2010	2011	2012	2013	2014
Medicare payments (billions of dollars)	$2.9	$3.1	$3.2	$3.3	$3.4	$3.6	$3.7	$3.9
Number of centers	4,740	4,941	5,049	5,135	5,217	5,287	5,363	5,347
New centers	343	282	220	195	198	169	164	125
Closed or merged centers	79	81	112	109	116	99	88	51
Net percent growth in number of centers from previous year	5.6%	4.2%	2.2%	1.7%	1.6%	1.3%	1.4%	1.4%
Percent of all centers that are:								
For profit	95	95	95	95	95	95	95	95
Nonprofit	4	4	3	3	3	3	3	3
Government	1	1	1	1	1	1	2	2
Urban	92	92	92	92	92	93	93	93
Rural	8	8	8	8	8	7	7	7

Note: ASC (ambulatory surgical center). Medicare payments include program spending and beneficiary cost sharing for ASC facility services. Payments for 2014 are preliminary and subject to change. Totals may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Provider of Services file from CMS 2014. Payment data are from CMS, Office of the Actuary.

- ASCs are distinct entities that furnish ambulatory surgical services not requiring an overnight stay. The most common ASC procedures are cataract removal with lens insertion, upper gastrointestinal endoscopy, colonoscopy, and nerve procedures.
- Total Medicare payments for ASC services increased by 4.2 percent per year, on average, from 2007 through 2014. Payments per fee-for-service beneficiary grew by 3.9 percent per year during this period. Between 2013 and 2014, total payments rose by 4.3 percent and payments per beneficiary grew by 4.0 percent.
- The number of Medicare-certified ASCs grew at an average annual rate of 2 percent from 2007 through 2014. Each year from 2007 through 2014, an average of 212 new facilities entered the market, while an average of 92 closed or merged with other facilities.
- The slower growth in the number of ASCs from 2009 through 2014 may reflect the substantially higher rates that Medicare pays for ambulatory surgical services in hospital outpatient departments than in ASCs, the very slow growth of national health care spending and Medicare spending, and the significant increase in hospital employment of physicians.

Chart 7-17. Medicare spending for imaging services under the fee schedule for physicians and other health professionals, by type of service, 2013



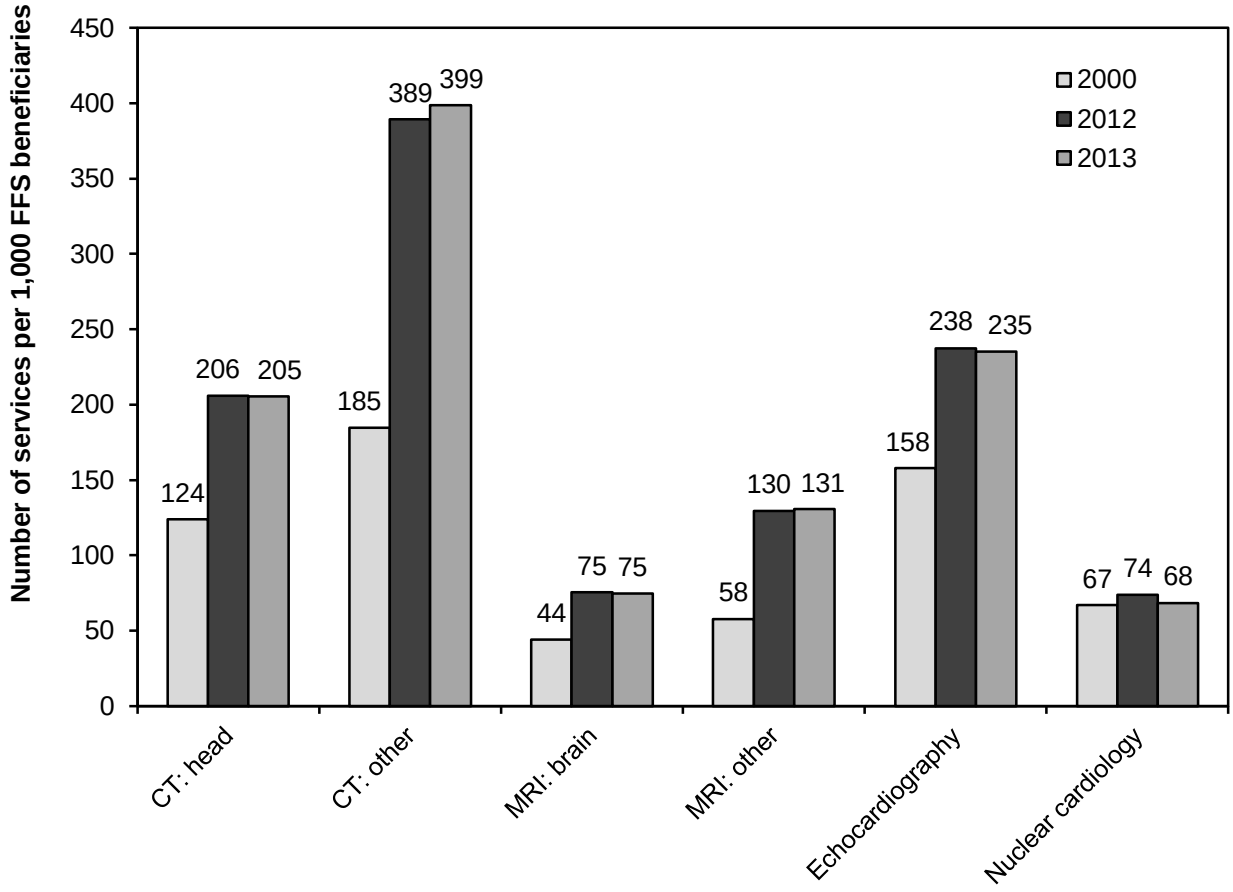
Note: PET (positron emission tomography), MRI (magnetic resonance imaging), CT (computed tomography). Standard imaging includes chest, musculoskeletal, and breast X-rays. Imaging procedures include stereoscopic X-ray guidance for delivery of radiation therapy, fluoroguide for spinal injection, and other interventional radiology procedures. Medicare payments include program spending and beneficiary cost sharing for fee schedule imaging services provided in all settings. Payments include carrier-priced codes but exclude radiopharmaceuticals.

Source: MedPAC analysis of 100 percent physician/supplier procedure summary file from CMS 2013.

- About one-third of Medicare spending for imaging under the fee schedule for physicians and other health professionals in 2013 was for CT and MRI studies. About one-quarter was for various types of ultrasound (echocardiography and other echography).

- Medicare and beneficiaries spent a total of $9.6 billion for imaging services under the fee schedule in 2013. Spending declined from $9.9 billion in 2012 (–3.2 percent). The decline in spending was largely due to a 1 percent drop in the number and complexity of imaging services per beneficiary in 2013, CMS's adoption of more current practice-expense data from a new survey of practitioners, and CMS's update of the interest rate assumption for medical equipment such as imaging machines.

Chart 7-18. Growth in the number of CT, MRI, and cardiac imaging services per 1,000 beneficiaries, 2000–2013



Note: CT (computed tomography), MRI (magnetic resonance imaging), FFS (fee-for-service). Data include physician fee schedule imaging services provided in all settings but exclude technical component–only services. The number of echocardiography and nuclear cardiology services excludes add-on services.

Source: MedPAC analysis of 100 percent physician/supplier procedure summary files from CMS 2000, 2012, and 2013.
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- The number of CT and MRI scans per 1,000 fee-for-service beneficiaries grew rapidly from 2000 to 2012. There was minimal change from 2012 to 2013. For example, the number of CT scans of parts of the body other than the head ("CT: other") more than doubled from 2000 to 2013 (from 185 per 1,000 beneficiaries to 399).

- The number of echocardiography and nuclear cardiology studies also increased from 2000 to 2012, although not as much as CT and MRI scans.

- Echocardiography services per 1,000 beneficiaries grew by 51 percent from 2000 to 2012 and declined by 1 percent in 2013. Nuclear cardiology studies increased by 11 percent from 2000 to 2012 and fell by 7 percent in 2013.